Virtual Integrated Care Management (ICM) Train-the-Trainer and Certification

Gain CEUs and ICM Specialist Trainer Certificate

Live Webex Training Series Dates *

June 5, 2018: 1:00PM – 3:00PM
June 12, 2018: 1:00PM – 3:00PM
June 19, 2018: 1:00PM – 3:00PM
June 26, 2018: 1:00PM – 3:00PM

**Attendance is required of all four live trainings plus all self-paced online modules for trainer certification.*

Train the Trainer Specialist Exam/Certificate

Upon successful completion of all live and self-paced sessions, as well as a web-based examination, participants will receive an *Integrated Care Management Specialist Trainer Certificate*. As an authorized trainer, you will gain access to training materials including PDFs of all slide decks and activities used in each class, plus four stoplight tools on Heart failure, COPD, diabetes and depression. You'll also be able to provide in-service trainings to colleagues or new hires at your agency.

Participants will receive **12 CEUs** for nursing and therapy in states that accept California-awarded CEUs. *This course is endorsed by the National Association for Homecare and Hospice (NAHC).*

HCA
EDUCATION AND RESEARCH

To thrive in a value-based payment environment, health care providers must equip their clinicians with the tools and competencies necessary to engage patients, reduce unnecessary utilization, and promote high-level patient satisfaction.

Integrated Care Management (ICM) is a person-centered, evidence-based care delivery model that fulfills these goals. It provides cross-setting support, with a focus on self-management, care transitions, and case management best practices for communication and coordination. An effective ICM program helps clinicians to clearly articulate the value of these competencies to patients, families and other stakeholders. These and other characteristics make it a valuable asset in achieving new standards under the recently expanded home health Conditions of Participation (CoPs).

Join faculty experts from the acclaimed Sutter Center for Integrated Care for a one-of-its kind ***Virtual ICM Train-the-Trainer*** program in June. This series includes **four 2-hour live webinar sessions** as well as **four self-paced online training modules** designed to solidify competencies for successfully implementing an ICM program with evidence-based guidelines targeting four chronic conditions: heart failure, diabetes, COPD, and depression.

Participants will learn how to develop:

- Continuous, integrated care processes across all aspects of home health services;
- Patient-centered, interdisciplinary approaches that recognize the contributions of various skilled professionals; and
- An evidence and outcome-based approach to patient care that can be understood by the patient and caregivers and incorporates the shared decision-making model.

ICM is founded on the most effective practices, interventions and tools in the most recent literature. Its goal is to take the "best of the best" and maximize patient support where the patient faces daily challenges – the home.

Live Webex Sessions Content:

- Overview of chronic care and patient engagement best practices, including Wagner's Care Model, health care policy research findings, and the Integrated Care Model
- Motivational interviewing and health coaching
- Interventions for patients with low health literacy and patient education best practices
- Overview of the Transitions of Care best practices
- Pivotal role of the integrated care manager in the future health care environment
- Tips and takeaways for hardwiring ICM best practices

Self-Paced Online Modules Content:

Evidence-based guidelines and patient behaviors needed for optimal condition management of the following:

- Heart Failure
- Diabetes
- COPD
- Depression

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ICM Faculty

Beth Hennessey, RN, BSN, MSN

Beth has over 40 years of healthcare experience in a variety of settings including acute care, case management, medical practice management, home care, higher education, and now as the Executive Director of the Sutter Center for Integrated Care. Beth's passion is the development, implementation, and evaluation of innovative approaches for true person-centered care delivery.

Beth has published widely in refereed journals on best practices in patient centered care, "what matters most", chronic care management, transitions of care, patient engagement, health literate care, and successfully positioning providers across the continuum to meet the quadruple aim of healthcare reform.

Beth has served on multiple state and national workgroups some of which include: National Association of Home Care and Hospice Board, VNAA Policy Board, Alliance for Home Health Quality and Innovation Transitions of Care workgroup, CMS Expert Panel on Patient Engagement Measures, Arkansas Home Care Association Board, and CMMI Comprehensive Primary Care Initiative AR Core Workgroup.

Paula Suter, RN, BSN, MA

Paula is the Clinical Manager of Integrated Care Management (ICM) at the Sutter Center for Integrated Care. Drawing from her clinical and academic experience, she designs, implements, and evaluates person-centered health care delivery programs to meet the needs of patients and populations. Paula is passionate about advancing excellence in home and community care, establishing this sector as a value added partner for healthcare reform. She has more than 30 years of health care clinical and leadership experience in a variety of settings including home care, acute care, intensive care, cardiac rehab, education, and research.

Prior to joining Sutter, Paula co-developed the Home-Based Chronic Care Model™ which received national awards for excellence from the National Association of Homecare and Hospice and Modern Healthcare. She currently sits on the executive committee for a national health care quality initiative, is a member of the VNAA Best Practice workgroup, and has served as a reviewer for a leading homecare journal. In 2012, Paula was selected as one of 73 participants in the Centers for Medicare and Medicaid (CMMI) Innovation Advisors Program. Drawing from the advanced skill set acquired through successful completion of this program, she offers training and support to providers nationwide.

REGISTRATION

Name: _____

Title/Profession: _____

Agency: _____

Address: _____

City/State/Zip: _____

Phone: _____ Ext. _____

Email: _____

REGISTRATION FEES *(per person NOT per connection)*

☐ $499 HCA Member

☐ $649 Non-Member *(Within New York State)*

Out of New York State Providers

☐ $499 I am a member of my state home care association
(please specify) _____

☐ $649 I am not a member of my state home care association

PAYMENT

____MasterCard ____VISA ____ American Express ____ Check*

*Make checks payable and mailed to: HCA Education and Research
388 Broadway, 4th Floor, Albany, NY 12207

_____ _____ _____
Card Number Expiration Date Security Code

_____
Name and/or Company Name on Card

_____
Billing Address of card (including City, State and Zip Code)

_____
Authorized Signature

CANCELLATIONS

must be received in writing via e-mail to info@hcanys.org. Cancellations received by May 22 are refundable less a 25% administrative fee. No refunds will be given once course materials and log-in information have been provided. No refunds will be provided for no shows. Substitutions (for the entire program only) are permitted. DO NOT FORWARD YOUR ACCESS LINK: you must notify us in advance of the substitution to ensure your agency is not charged for an additional registration.

FAX TO: (518) 426-8788